Revised 06/01/02

DIVISION OF MEDICAID - LONG-TERM CARE FACILITY COST REPORT REVIEW CHECKLIST

MediMax Technologies, MSFCRS V2.0, 05/2002 Printed: **05/31/2002 2:42:49 PM**

Facility Name:

D/B/A (If Applicable)

Provider Number: Period: From To

FORM/SCHEDULE	REFERENCE	YES	NO
Cost Report			
Form 1, General Information			
Management Agreement			
Form 2, Certification			
Original Signature	Must be Signed By Officer or Administrator		
Accountant's Report			
Form 3, Statistical Data			
Form 4, Patient Days			
Form 5, Revenue and Expense Statement			
Form 6, Pages 1-4, Expenses			
Form 7, Fixed Assets & Depr			
Form 8, Related Org.			
Form 9, Rental of PP&E			
Form 10, Debt & Related Int			
Form 11, Pages 1-2, B/S			
Form 12, Capital Reconciliation	Net Income must match Form 5, Line 25		
Form 13, Pages 1-3, Return on Net Working Capital	Column 1 balances must tie to Form 11		
Form 14, <80% Occupancy, 3 pages	Must be completed if % of occupancy is less than 80% of Form 4		
Form 15, Pages 1-3, Owners Comp	A separate Form 15 must be submitted for each owner officer (regardless of the compensation) and for each director receiving compensation other than director fees. Each Form 15 must have original signatures.		
Form 16, Ownership Disclosure			
Form 17, Pages 1-2, Home Office/Related Management Company Cost Report			
Form 18, Computation of Return on Net Working Capital for Home Office or Related Management Company			
Schedule 1, Other Income	Must agree with Form 5, Line 13		
Schedule 2, Direct Care Allocated Costs	Must agree with Form 6, Line 1-17		
Schedule 3, Therapy Allocated Costs	Must agree with Form 6, Line 2-16		
Schedule 4, Care Related Allocated Costs	Must agree with Form 6, Line 3-23		
Schedule 5, Miscellaneous Expense	Must agree with Form 6, Line 4-37		
Schedule 6, Taxes & Licenses	Must agree with Form 6, Line 4-43		
Schedule 7, Travel Expenses	Must agree with Form 6, Line 4-45		
Schedule 8, Administrative & Operating Allocated Costs	Must agree with Form 6, Line 4-47		
Schedule 9, Property & Equip. Allocated Costs	Must agree with Form 6, Line 5-08		
Schedule 10, Other Non-Allowable Costs	Must agree with Form 6, Line 6-10		
Schedule 11, Non-Allowable Allocated Costs	Must agree with Form 6, Line 6-15		
Schedule 12, Deposits	Must agree with Form 11, Page 1, Line 19		
Schedule 13, Other Income	Must agree with Form 17, Line 1-08		
Schedule 14, Consultants	Must agree with Form 17, Line 2-11		
Schedule 15, Taxes & Licenses	Must agree with Form 17, Line 2-23		
Schedule 16, Travel Expenses	Must agree with Form 17, Line 2-25		
Schedule 17, Other Expenses	Must agree with Form 17, Line 2-27		
Depreciation Schedule	Must tie to Form 7		
Amortization Schedule	Must support Form 6, Lines 4-23 and 5-01 and Form 17, Line 2-10		
Trial Balance (Form 6 & Form 17)	Must tie to Form 5 and Form 6, Column 1 and to Form 11, Column 2 & Form 17 & Form 18		
Adjustments Workpaper	Form 6 & Form 17 adjustments		
Hold Harmless Documentation	Must be submitted if the facility receives a hold harmless payment		
Medicare C/R Sch.S-2, A, A-6, A-7, A-8, A-8-1, B Part 1, B-1	Must be submitted if facility is state owned or hospital based with allocated costs		
Other Attached Schedules			

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STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID
LONG-TERM CARE PROVIDERS

Form 1 - General Information

I. PROVIDER FACILITY

Facility Name | Provider Number

D/B/A (If Applicable)

Address

Administrator | MS License # | Phone: | Fax #:

Contact Person | Title: | Phone: | Fax #:

REPORT PERIOD: FROM **TO** Number of Months

Financial Records For Audit Are Located At:

All Correspondence and Desk Reviews Regarding This Cost Report Should Be Addressed To (Limited to one name and address):

Telephone: Fax #:

II. COMPLETE THIS SECTION IF THIS IS AN AMENDED COST REPORT

Reason for Amendment:

III. LIST ALL OTHER ENTITIES RECORDED IN THE FACILITY'S GENERAL LEDGER. (IF APPLICABLE)

IV. HOME OFFICE (IF APPLICABLE)

Name of Home Office

Address

Contact Person | Phone: | Fax #:

Names of Other Nursing Home Facilities in Mississippi Owned By The Above:

V. MANAGEMENT COMPANY (IF APPLICABLE)

Name of Management Company

Address

Contact Person | Phone: | Fax #:

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STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID
LONG-TERM CARE PROVIDERS

FORM 2 - CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER

Facility Name _____ Provider Number _____

D/B/A (If Applicable) _____

Address _____

The enclosed cost report is submitted for the cost reporting period beginning _____

and ending _____

INTENTIONAL MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER STATE OR FEDERAL LAW.

This Cost report is submitted as a part of the request by this Long-Term Care Provider for reimbursement under the Mississippi Medicaid Program.

I HEREBY CERTIFY that I have examined the contents of the accompanying cost report to the State of Mississippi, Office of the Governor, Division of Medicaid for the period stated above and certify to the best of my knowledge and belief that the said contents are true and correct statements prepared from the books and records of this facility in accordance with applicable instructions.

(Signed) _____

Officer or Administrator of Provider

_____

Name of Person Signing

_____

Title

_____

Date

Cost Report Prepared By:

Name _____

Address _____

_____

_____

Name of Contact Person _____

Telephone Number _____

NOTE: If the cost report was prepared by an independent CPA, an accountant's report must be attached.

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STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID
LONG-TERM CARE PROVIDERS

FORM 3 - STATISTICAL DATA

FACILITY NAME

D/B/A (If Applicable)

PROVIDER NUMBER PERIOD: From To

1. Type of Control:

   Nonprofit: [ ]Church [ ]Other

   Proprietary: [ ]Individual [ ]Partnership [ ]Corporation

   Government Operated: [ ]State [ ]County

2. A) Facility: [ ]Owned [ ]Leased

   B) Part of Nursing Home Chain: [ ] Yes [ ]No

   C) Hospital Based: [ ] Yes [ ]No

   D) Use of Facility:

	Column 1		Column 2	Column 3	Column 4	Column 5
	Yes	No	Patient Days	# of Beds	Square Feet	Shared Area Square Feet
1. Medicaid Certified Portion	[ ]	[ ]				
2. Assisted Living	[ ]	[ ]				
3. CORF	[ ]	[ ]	N/A	N/A		
4. Hospital	[ ]	[ ]				
5. NH Licensure Only	[ ]	[ ]				
6. Outpatient Therapy	[ ]	[ ]	N/A	N/A		
7. Personal Care	[ ]	[ ]				
8. Rented Space	[ ]	[ ]	N/A	N/A		
9. SNF Only	[ ]	[ ]				
10. Other (Describe) _____	[ ]	[ ]				
E) Total Facility Square Footage						

3. Classification: [ ] Nursing Facility
   [ ] Psychiatric Residential Treatment Facility
   [ ] ICF-MR

4. Accounting Basis: [ ] Accrual [ ] Cash [ ] Other

5. Patient Days:	Column A Total	Column B Medicaid	Column C Medicare	Column D Private	Column E Other

6. Medicaid Certified Beds at Beginning of Period	1.	2.	3.	4.
7. Medicaid Certified Beds at End of Period				
8. Date of Change in Number of Beds, if Applicable				

9. Bed Days Available for Period	
10. Percentage of Occupancy (Line 5, Total Column (A) / Line 9)	
11. Percentage of Medicaid Utilization (Line 5, Column (B) / Line 5, Column (A))	
12. Number of Total ICF-MR Respite Hours	

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STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID
LONG-TERM CARE PROVIDERS
FORM 4 - PATIENT DAY STATISTICS

Facility Name

D/B/A (If Applicable)

Provider Number Period: From To

I. Monthly Patient Days

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6	Column 7	Column 8
MONTH	**MEDICAID DAYS**	**MEDICARE DAYS**	**PRIVATE DAYS**	**OTHER DAYS**	**TOTAL PATIENT DAYS**	**BED DAYS AVAILABLE**	**PERCENTAGE OF OCCUPANCY**
TOTALS							

NOTE: Holding and Leave Days are to be included in the Monthly Patient Days listed above. The totals should agree with the days on Form 3, line 5

II. Private Pay Rates

List the facility's private pay rates during the reporting period. If a change of rates occurred during the period, list each rate structure and the dates the rates were in effect.

DATES EFFECTIVE		**PRIVATE ROOM RATE**	**SEMI-PRIVATE RATE**
FROM	**TO**		

FORM 4

DOM 500-5
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STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID
LONG-TERM CARE PROVIDERS

Form 5 - Statement of Revenues & Expenses

Facility Name

D/B/A (If Applicable)

Provider Number Period: From To

DESCRIPTION	Column 1 PER GENERAL LEDGER	Column 2 Medicaid Certified Portion of Long Term Care Facility	Column 3 ADJUSTMENT TO FORM 6 COLUMN 4	Column 4 ADJUSTMENT Line Number Reference
1. Patient Revenues				
2. Less - Allowances and Discounts on Patients Accounts				
3. Net Patient Revenues				
4. Total Operating Expenses (Form 6, Line 7, Column 1)				
5. Net Income from Services to Patients				
OTHER INCOME				
6. Barber and Beauty Income				
7. Contributions, Gifts, Grants, etc.				
8. Guest & Employee Meals Revenue				
9. Interest Income				
10. Nurse Aide Training & Testing Reimbursement				
11. Nursing Supplies				
12. Other Ancillary Services Revenue Including Medicaid Crossover Payments				
13. Other Income (Schedule 1)				
14. Occupational Therapy Income				
15. Pharmacy Revenue				
16. Physical Therapy Income				
17. Rental Income				
18. Respiratory Therapy Income				
19. Respite Services Income				
20. Speech Therapy Income				
21. State Appropriations				
22. Television, Telephone Income				
22. Vending Machines Revenue				
24. Total Other Income				
25. Net Income (Total of Lines 5 and 24)(Form 12, Line 1)	$			

FORM 5

STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID
LONG-TERM CARE FACILITIES
FORM 6 - SCHEDULE OF EXPENSES

Facility Name						
D/B/A (If Applicable)						
Provider Number		Period: From			To	
Line No.	Account	Expense Per Books Column 1	Reclassifi-cations Column 2	Total Expense Column 3	Adjustments Column 4	Allowable Expense Column 5
1	**DIRECT CARE EXPENSES**					
1-01	Salaries-Aides					
1-02	Salaries-LPN's					
1-03	Salaries-RN's (exclude DON & RAI Coordinator)					
1-04	FICA-Direct Care					
1-05	Group Insurance-Direct Care					
1-06	Pensions-Direct Care					
1-07	Unemployment Taxes-Direct Care					
1-08	Uniform Allowance-Direct Care					
1-09	Workmens' Comp-Direct Care					
1-10	Contract-Aides					
1-11	Contract-LPN's					
1-12	Contract-RN's					
1-13	Drugs - Over-the-Counter and Legend					
1-14	Medical Supplies-Direct Care					
1-15	Medical Waste Disposal					
1-16	Other Supplies-Direct Care					
1-17	Allocated Costs-Hospital Based & State Facilities (Schedule 2)					
1-18	Total Direct Care Expenses					
2	**THERAPY EXPENSES**					
2-01	Salaries-Occupational Therapists					
2-02	Salaries-Physical Therapists					
2-03	Salaries-Speech Therapists					
2-04	Salaries-Other Therapists					
2-05	FICA-Therapies					
2-06	Group Insurance-Therapies					
2-07	Pensions-Therapies					
2-08	Unemployment Taxes-Therapies					
2-09	Uniform Allowance-Therapies					
2-10	Workmens' Comp-Therapies					
2-11	Contract-Occupational Therapists					
2-12	Contract-Physical Therapists					
2-13	Contract-Speech Therapists					
2-14	Contract-OtherTherapists					
2-15	Therapy Costs - Other					
2-16	Allocated Costs-Hospital Bases & State Facilities (Schedule 3)					
2-17	**Total Therapy Expenses**					

STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID
LONG-TERM CARE FACILITIES
FORM 6 - SCHEDULE OF EXPENSES

Facility Name						
D/B/A (If Applicable)						
Provider Number		Period: From			To	
Line No.	Account	Expense Per Books Column 1	Reclassifi-cations Column 2	Total Expenses Column 3	Adjustments Column 4	Allowable Expense Column 5
3	**CARE RELATED EXPENSES**					
3-01	Salaries-Activities					
3-02	Salaries-Assistant Director of Nursing					
3-03	Salaries-Director of Nursing					
3-04	Salaries-Resident Assessment Instrument Coordinator					
3-05	Salaries-Pharmacy					
3-06	Salaries-Social Services					
3-07	FICA-Care Related					
3-08	Group Insurance-Care Related					
3-09	Pensions-Care Related					
3-10	Unemployment Taxes-Care Related					
3-11	Uniform Allowance-Care Related					
3-12	Workmens' Comp-Care Related					
3-13	Barber & Beauty Expense-Allowable					
3-14	Consultant Fees-Activities					
3-15	Consultant Fees-Medical Director					
3-16	Consultant Fees-Nursing					
3-17	Consultant Fees-Pharmacy					
3-18	Consultant Fees-Social Worker					
3-19	Consultant Fees-Therapists					
3-20	Food-Raw					
3-21	Food-Supplements					
3-22	Supplies-Care Related					
3-23	Allocated Costs-Hospital Based & State Facilities (Schedule 4)					
3-24	**Total Care Related Expenses**					

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STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID
LONG-TERM CARE FACILITIES
FORM 6 - SCHEDULE OF EXPENSES

Facility Name

D/B/A (If Applicable)

Provider Number Period: From To

Line No.	Account	Expense Per Books Column 1	Reclassifi-cations Column 2	Total Expense Column 3	Adjustments Column 4	Allowable Expense Column 5
4	**ADMINISTRATIVE AND OPERATING**					
4-01	Salaries-Administrator					
4-02	Salaries-Assistant Administrator					
4-03	Salaries-Dietary					
4-04	Salaries-Housekeeping					
4-05	Salaries-Laundry					
4-06	Salaries-Maintenance					
4-07	Salaries-Medical Records					
4-08	Salaries-Other Administrative					
4-09	Salaries-Owner or Owner/Administrator					
4-10	FICA-Admin. & Operating					
4-11	Group Insurance-Admin. & Operating					
4-12	Pensions-Admin. & Operating					
4-13	Unemployment Taxes-Admin. & Operating					
4-14	Uniform Allowance-Admin. & Operating					
4-15	Workmens' Comp-Admin. & Operating					
4-16	Contract-Dietary					
4-17	Contract-Housekeeping					
4-18	Contract-Laundry					
4-19	Contract-Maintenance					
4-20	Consultant Fees-Dietician					
4-21	Consultant Fees-Medical Records					
4-22	Accounting Fees					
4-23	Amortization Expenses-Non Capital					
4-24	Auto Lease					
4-25	Bank Service Charges					
4-26	Board of Directors Fees					
4-27	Dietary Supplies					
4-28	Depreciation (Form 7, Section I, Column 5)					
4-29	Dues					
4-30	Education Seminars & Training					
4-31	Housekeeping Supplies					
4-32	Insurance-Professional Liability and Other					
4-33	Interest Expense-Non-Capital & Vehicles					
4-34	Laundry Supplies					
4-35	Legal Fees					
4-36	Linen & Laundry Alternatives					
4-37	Miscellaneous (Schedule 5)					
4-38	Management Fees & Home Office Costs					
4-39	Non-Emergency Medical Transportation					
4-40	Office Supplies & Subscriptions					
4-41	Postage					
4-42	Repairs & Maintenance					
4-43	Taxes & Licenses (Schedule 6)					
4-44	Telephone & Communications					
4-45	Travel (Schedule 7)					
4-46	Utilities					
4-47	Allocated Costs-Hospital Based & State Facilities (Schedule 8)					
4-48	**Total Administrative & Operating Costs**					

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STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID
LONG-TERM CARE FACILITIES
FORM 6 - SCHEDULE OF EXPENSES

Facility Name

D/B/A (If Applicable)

Provider Number Period: From To

Line No.	Account	Expense Per Books Column 1	Reclassifications Column 2	Total Expense Column 3	Adjustments Column 4	Allowable Expense Column 5
5	**PROPERTY AND EQUIPMENT**					
5-01	Amortization Expense-Capital					
5-02	Depreciation (Form 7, Section 1, Column 6)					
5-03	Interest Expense-Capital					
5-04	Property Insurance					
5-05	Property Taxes					
5-06	Rent-Building					
5-07	Rent-Furniture & Equipment					
5-08	Allocated Costs-Hospital Based & State Facilities (Schedule 9)					
5-09	**Total Property and Equipment**					
6	**NON-ALLOWABLE COSTS**					
6-01	Advertising					
6-02	Bad Debts					
6-03	Barber and Beauty Expense					
6-04	Contributions					
6-05	Income Taxes-State & Federal					
6-06	Insurance-Officers					
6-07	Non-Medicaid Long Term Care Costs					
6-08	Nurse Aide Testing					
6-09	Nurse Aide Training					
6-10	Other Non-Allowable Costs (Schedule 10)					
6-11	Penalties & Sanctions					
6-12	Pharmacy					
6-13	Television					
6-14	Vending Machines					
6-15	Allocated Costs-Hospital Based & State Facilities (Schedule 11)					
6-16	**Total Non-Allowable Costs**					
7	**TOTAL COSTS**					
8	**TOTAL PATIENT DAYS (Form 3, Line 5, Total Column)**					

	COMPUTATION OF ALLOWABLE COST PER DAY (FACILITIES WITH LESS THAN 80% OCCUPANCY SHOULD COMPLETE FORM 14)	**Column A ALLOWABLE COST** (Column 5, above)	**Column B ALLOWABLE COST PER DAY** (Column A / Line 8)
9	Direct Care Costs (Line 1-18)		**.00**
10	Therapy Costs (Line 2-17)		**.00**
11	Care Related Costs (Line 3-24)		**.00**
12	Administrative and Operating Costs (Line 4-48)		**.00**
13	Property Costs (Line 5-09)		**.00**
14	Total Costs (Total should agree with Line 7)		**.00**

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STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID
LONG-TERM CARE PROVIDERS

Form 7, Page 1 of 2 - Schedule of Fixed Assets & Depreciation

Facility Name

D/B/A (If Applicable)

Provider Number Period: From To

I. SCHEDULE OF FIXED ASSETS

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6
Description of Property	Historical Cost	Medicaid Cost	Ending Accumulated Depreciation	Current Period Administrative and Operating Depreciation Expense	Current Period Property and Equipment Depreciation Expense
Land					
Buildings and Improvements					
Leasehold Improvements					
Furniture, Fixtures & Equipment					
Vehicles					
TOTALS					

II. RECONCILIATION OF COST REPORT PERIOD ACTIVITY			
1. Medicaid Cost, Beginning of Cost Report Period			
2. Additions During Cost Report Period (Section V, below)			
3. Deletions Druing Cost Report Period			
4. Medicaid Cost, End of Cost Report Period (Line 1 + Line 2 - Line 3)			

III. SPECIFY ANY ASSETS INCLUDED ON THIS FORM THAT ARE NOT RELATED TO PATIENT CARE

IV. COMPLETE FOR ALL OWNED VEHICLES

Type of Vehicle	Year	Total Miles Driven During Cost Report Period	Personal Miles Driven During Cost Report Period	Percentage Of Personal Usage	Total Current Depreciation Expense	Allowable Depreciation Expense
Totals						

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STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID
LONG-TERM CARE PROVIDERS

Form 7, Page 2 of 2 - Schedule of Fixed Assets & Depreciation (Cont'd)

Facility Name									
D/B/A (If Applicable)									
Provider Number			Period: From			To			
V. CURRENT PERIOD ASSET ADDITIONS									
Column 1	Column 2	Column 3	Column 4	Column 5	Column 6	Column 7	Column 8	Column 9	Column 10
Group/ Asset Number	**Asset Description**	**Date of Purchase**	**Asset Cost**	**Assets Not Used By Medicaid Certified Portion of LTC Facility**	**Assets Used Solely for the Medicaid Certified Portion of Long Term Care Facility**	**Shared Assets to be Allocated**	**Allocation Percentage**	**Basis Allocated to Medicaid Certified Portion of Long Term Care Facility**	**Total Asset Additions for Medicaid Long-Term Care Facility**
Total (Column 10 must agree to Section II, Line 2)									

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STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID
LONG-TERM CARE PROVIDERS

Form 8 - Facility Transactions with Related Organizations

Facility Name

D/B/A (If applicable)

Provider Number Period: From To

I. Are any costs included in the allowable costs on Form 6 which are a result of transactions with a related organization, as defined in HCFA Publication 15-1?

YES _____ NO _____
(If yes, comlete Section II. and III. below)

II. Costs incurred as a result of transactions with related organizations:

Form Number	Line Number	Name of Related Organization	Transaction Amount	Cost to Related Organization	Amount in Excess of Cost*

* Adjustment to expense should be made to the appropriate line on Form 6.

III. Name and percentage of ownership in the related organization:

Name of Owner	Name of Related Organization	Percent of Ownership

STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID
LONG-TERM CARE PROVIDERS

Form 9 - Rental of Property, Plant & Equipment

Facility Name

D/B/A (If Applicable)

Provider Number Period: From To

I. RENTAL PAYMENTS INCLUDED ON FORM 6, LINE 4-24

Lessor	Description of Property Leased	Description of Lease Terms	Total Miles Driven During Cost Report Period	Personal Miles Driven During Cost Report Period	Percentage Of Personal Usage	Column 1 Total Rental Expense	Column 2 Allowable Rental Expense
Total to Form 6, Line 4-24, Column 1							

II. RENTAL PAYMENTS INCLUDED ON FORM 6, LINE 5-06

Lessor	Description of Property Leased	Description of Lease Terms	Description of Purchase Option, If Any	Current Period Expense
Total to Form 6, Line 5-06, Column 1				

III. RENTAL PAYMENTS INCLUDED ON FORM 6, LINE 5-07

Lessor	Description of Property Leased	Description of Lease Terms	Description of Purchase Option, If Any	Current Period Expense
Total to Form 6, Line 5-07, Column 1				

STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID
LONG TERM CARE PROVIDERS

FORM 10 - ANALYSIS OF INTEREST BEARING DEBT AND RELATED INTEREST EXPENSE

Facility Name				
D/B/A (If Applicable)				
Provider Number	Period: From		To	
	Note 1	**Note 2**	**Note 3**	**Note 4**
1. Lender				
2. Beginning Balance				
3. Ending Balance				
4. Current Portion				
5. Long-Term Portion				
6. Terms of Debt				
7. Purpose of Loan				
8. Interest Rate				
9. Allowable Interest - Capital				
10. Allowable Interest - Non-Capital				
11. Non-Allowable Interest				
	Note 5	**Note 6**	**Note 7**	**Note 8**
1. Lender				
2. Beginning Balance				
3. Ending Balance				
4. Current Portion				
5. Long-Term Portion				
6. Terms of Debt				
7. Purpose of Loan				
8. Interest Rate				
9. Allowable Interest - Capital				
10. Allowable Interest - Non-Capital				
11. Non-Allowable Interest				
	Note 9	**Note 10**	**Note 11**	**TOTALS**
1. Lender				
2. Beginning Balance				
3. Ending Balance				
4. Current Portion				
5. Long-Term Portion				
6. Terms of Debt				
7. Purpose of Loan				
8. Interest Rate				
9. Allowable Interest - Capital				
10. Allowable Interest - Non-Capital				
11. Non-Allowable Interest				

STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID
LONG-TERM CARE PROVIDERS

Form 11, Balance Sheet - 2 Pages

Facility Name

D/B/A (If Applicable)

Provider Number Period: From To

Account Description	Column 1 Beginning of Reporting Period	Column 2 End of Reporting Period
ASSETS		
Current Assets:		
1. Cash on Hand and in Banks		
2. Accounts Receivable		
3. Less Allowance for Uncollectible Accounts		
4. Notes Receivable		
5. Due From Officers, Owners and/or Related Organizations		
6. Other Receivables		
7. Inter-Company Receivables		
8. Inventory		
9. Prepaid Expenses		
10. Investments		
11. Other Current Assets (List): Other -		
Other -		
Other -		
12. Total Current Assets		
Fixed Assets:		
13. Property, Plant and Equipment (Form 7)		
14. Less Accumulated Depreciation (Form 7)		
15. Total Fixed Assets		
Other Assets:		
16. Notes Receivable-Noncurrent		
17. Due From Officers, Owners and/or Related Organizations		
18. Goodwill		
19. Deposits (Schedule 12)		
20. Other Noncurrent Assets (List): Other -		
Other -		
Other -		
21. Total Other Assets		
22. TOTAL ASSETS	$	$

STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID
LONG-TERM CARE PROVIDERS

Form 11, Balance Sheet - 2 Pages

Facility Name

D/B/A (If Applicable)

Provider Number Period: From To

Account Description	Column 1 Beginning of Reporting Period	Column 2 End of Reporting Period
Current Liabilities:		
23. Accounts Payable		
24. Notes Payable and Current Portion of Long Term Debt		
25. Accrued Salaries		
26. Accrued Payroll Taxes		
27. Accrued Income Taxes		
28. Inter-Company Payables		
29. Other Current Liabilites (List) Other -		
Other -		
Other -		
30. Total Current Liabilities		
Long-Term Liabilities:		
31. Notes Payable		
32. Notes Payable to Officers, Owners and/or Related Organizations		
33. Total Long-Term Liabilities		
34. TOTAL LIABILITIES		
Capital:		
35. Individual		
36. Partnership - Partners' Capital Accounts		
37. State, County or Other - Fund Balance		
38. Capital Stock		
39. Additional Paid-in Capital		
40. Retained Earnings		
41. Treasury Stock		
42. TOTAL CAPITAL		
43. TOTAL LIABILITIES AND CAPITAL	$	$

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STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID
LONG-TERM CARE PROVIDERS

Form 12 - Capital Reconciliation

Facility Name		
D/B/A (If Applicable)		
Provider Number Period: From To		
Total Capital at Beginning of Period (Form 11, Line 42, Column 1)		$ 0
Additions to Capital		
1. Net Income for Period (Form 5, Line 25)	$ 0	
2. Contributions to Capital (include date and amount of each transaction)		
3.		
4.		
Total Additions to Capital		
Subtotal		
Reductions to Capital		
1. Dividends Paid		
2. Owners' or Partners' Withdrawals (include date and amount of each transaction)		
3.		
4.		
Total Reductions to Capital		
Total Capital at End of Reporting Period (Form 11, Line 42, Column 2)		$

Transaction Date	Transaction Amount

Transaction Date	Transaction Amount

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Form 13, Page 1 of 3 - Computation of Return on Net Working Capital

Facility Name				
D/B/A (If Applicable)				
Provider Number	Period: From		To	
	Adjustments			
	Column 1	**Column 2**	**Column 3**	**Column 4**
Description	**Balance Per Books**	**Additions**	**Reductions**	**Net Working Capital**
1. Equity Capital Beginning of Reporting Period Per Prior Period Cost Report				
2. Equity Capital End of Reporting Period (Form 11, Line 42, Column 2)				
3. Total				
4. Average Net Working Capital (Line 3, Column 4 / 2)				
5. Limitation on Net Working Equity (Total Allowable Costs, Form 6, Line 7, Column 5 divided by # Months in Reporting Period X 2)				
6. Net Working Capital Subject to Return (Lesser of Line 4 or Line 5)				
7. Authorized Rate of Return				**9.50**
8. Return on Equity Payment (Line 6 X Line 7)				
9. Patient days reported (Form 3, Line 5, Column A)				
10. Number of Months in Reporting Period (Round to 2 decimals)				
11. Number of Months in Year			**12**	
12. Annualized Patient Days (Line 9 divided by Line 10 X Line 11)				
13. Per Diem Return on Equity Payment (Line 8 divided by Line 12)				

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Form 13, Page 2 of 3 - Computation of Return on Net Working Capital (Cont'd)

Facility Name

D/B/A (If Applicable)

Provider Number Period: From To

Additions to Beginning Equity Capital:

Description	Amount
Total Additions to Beginning Equity Capital (To Form 13, Line 1, Column 2)	$ 0

Reductions to Beginning Equity Capital:

Description	Amount
Total Reductions to Beginning Equity Capital (To Form 13, Line 1, Column 3)	$ 0

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Form 13, Page 3 of 3 - Computation of Return on Net Working Capital (Cont'd)

Facility Name	
D/B/A (If Applicable)	
Provider Number Period: From To	

Additions to Ending Equity Capital:

Description	Amount
Total Additions to Ending Equity Capital (To Form 13, Line 2, Column 2)	$ 0

Reductions to Ending Equity Capital:

Description	Amount
Total Reductions to Ending Equity Capital (To Form 13, Line 2, Column 3)	$ 0

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FORM 14 - COMPUTATION OF PER DIEM COST FOR FACILITIES WITH LESS THAN 80% OCCUPANCY

Facility Name				
D/B/A (If Applicable)				
Provider Number	Period: From	To		
Form 6 Line No.	Account Description	Column 1 Total Allowable Cost	Column 2 Variable Cost	Column 3 Fixed Cost
3	**CARE RELATED EXPENSES**			
3-01	Salaries-Activities			
3-02	Salaries-Assistant Director of Nursing			
3-03	Salaries-Director of Nursing			
3-04	Salaries-Resident Assessment Instrument Coordinator			
3-05	Salaries-Pharmacy			
3-06	Salaries-Social Services			
3-07	FICA-Care Related			
3-08	Group Insurance-Care Related			
3-09	Pensions-Care Related			
3-10	Unemployment Taxes-Care Related			
3-11	Uniform Allowance-Care Related			
3-12	Workmens' Comp-Care Related			
3-13	Barber & Beauty Expense-Allowable			
3-14	Consultant Fees-Activities			
3-15	Consultant Fees-Medical Director			
3-16	Consultant Fees-Nursing			
3-17	Consultant Fees-Pharmacy			
3-18	Consultant Fees-Social Worker			
3-19	Consultant Fees-Therapists			
3-20	Food-Raw			
3-21	Food-Supplements			
3-22	Supplies-Care Related			
3-23	Allocated Costs-Hospital Based & State Facilities (Schedule 4)			
3-24	**Total Care Related**			

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FORM 14 - COMPUTATION OF PER DIEM COST
FOR FACILITIES WITH LESS THAN 80% OCCUPANCY

Facility Name
D/B/A (If Applicable)
Provider Number Period: From To :

Form 6 Line No.	Account Description	Column 1 Total Allowable Cost	Column 2 Variable Cost	Column 3 Fixed Cost
4	**ADMINISTRATIVE AND OPERATING**			
4-01	Salaries-Administrator			
4-02	Salaries-Assistant Administrator			
4-03	Salaries-Dietary			
4-04	Salaries-Housekeeping			
4-05	Salaries-Laundry			
4-06	Salaries-Maintenance			
4-07	Salaries-Medical Records			
4-08	Salaries-Other Administrative			
4-09	Salaries-Owner or Owner/Administrator			
4-10	FICA-Admin. & Operating			
4-11	Group Insurance-Admin. & Operating			
4-12	Pensions-Admin. & Operating			
4-13	Unemployment Taxes-Admin. & Operating			
4-14	Uniform Allowance-Admin. & Operating			
4-15	Workmens' Comp-Admin. & Operating			
4-16	Contract-Dietary			
4-17	Contract-Housekeeping			
4-18	Contract-Laundry			
4-19	Contract-Maintenance			
4-20	Consultant Fees-Dietician			
4-21	Consultant Fees-Medical Records			
4-22	Accounting Fees			
4-23	Amortization Expense-Non-Capital			
4-24	Auto Lease			
4-25	Bank Service Charges			
4-26	Board of Directors Fees			
4-27	Dietary Supplies			
4-28	Depreciation Expense-See Instructions			
4-29	Dues			
4-30	Educational Seminars & Training			
4-31	Housekeeping Supplies			
4-32	Insurance-Professional Liability and Other			
4-33	Interest Expense-Non-Capital & Vehicles			
4-34	Laundry Supplies			
4-35	Legal Fees			
4-36	Linen & Laundry Alternatives			
4-37	Miscellaneous (Schedule 5)			
4-38	Management Fees & Home Office Costs			
4-39	Non-Emergency Medical Transportation			
4-40	Office Supplies & Subscriptions			
4-41	Postage			
4-42	Repairs & Maintenance			
4-43	Taxes & Licenses (Schedule 6)			
4-44	Telephone & Communications			
4-45	Travel (Schedule 7)			
4-46	Utilities			
4-47	Allocated Costs-Hospital Based & State Facilities (Schedule 8)			
4-48	**Total Administrative & Operating**			

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FORM 14 - COMPUTATION OF PER DIEM COST FOR FACILITIES WITH LESS THAN 80% OCCUPANCY

Facility Name		
D/B/A (If Applicable)		
Provider Number	Period: From	To

Computation of Allowable Cost Per Day

A.	**Patient Days**	
A-1	Total Patient Days (from Form 3, Line 5, Column A)	
A-2	Bed Days Available for Period (from Form 3, Line 9)	
A-3	Bed Days Available X 80% (Line A-2 X 80%)	
B.	**Care Related Costs**	
B-1	Care Related Variable Costs (from Line 3-24, Column 2 above)	**0**
B-2	Bed Days Care Related Variable Costs Per Day (Line B-1 / Line A-1)	
B-3	Care Related Fixed Costs (from Line 3-24, Column 3, above)	**0**
B-4	Care Related Fixed Costs Per Day (Line B-3 / Line A-3)	
B-5	Care Related Cost Per Day (Line B-2 + Line B-4)	**0.00**
C.	**Administrative and Operating Costs**	
C-1	Administrative and Operating Variable Costs (from Line 4-48, Column 2, above)	**0**
C-2	Administrative and Operating Variable Cost Per Day (Line C-1 / Line A-1)	
C-3	Administrative and Operating Fixed Costs (from Line 4-48, Column 3, above)	**0**
C-4	Administrative and Operating Fixed Cost Per Day (Line C-3 / Line A-3)	
C-5	Administrative and Operating Cost Per Day (Line C-2 + Line C-4)	**0.00**
D.	**Calculation of Allowable Costs Per Day**	
D-1	Direct Care Cost Per Day (Form 6, Line 1-18, Column 5 / Form 6, Line 8)	
D-2	Therapy Cost Per Day (Form 6, Line 2-17, Column 5 / Form 6, Line 8)	
D-3	Care Related Cost Per Day (From Line B-5, above)	**0.00**
D-4	Administrative and Operating Cost Per Day (From Line C-5, above)	**0.00**
D-5	Property Cost Per Day (Form 6, Line 5-09 / Form 6, Line 8)	
D-6	Total Allowable Cost Per Day	**0.00**

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FORM 15 - OWNERS, OFFICERS AND DIRECTORS COMPENSATION

Facility Name		
D/B/A (If Applicable)		
Provider Number	Period: From	To

NOTE: A FORM 15 MUST BE INCLUDED FOR EACH OWNER OR OFFICER OF THE ORGANIZATION, WHETHER COMPENSATION IS CLAIMED OR NOT. AN OWNER IS DEFINED AS SOMEONE OWNING FIVE PERCENT (5%) OR MORE OR HAVING CONTROL OF THE ORGANIZATION. A FORM 15 MUST BE INCLUDED FOR EACH DIRECTOR FOR WHOM COMPENSATION, EXCLUDING BOARD OF DIRECTOR FEES, IS CLAIMED ON THE COST REPORT.

Name of Owner, Officer or Director

I. **Compensation Paid (includes compensation paid through the facility or allocated from the home office and/or related management company):**	**Form 6 Line Number**	**Amount Included in Column 5 of Form 6**
Salary		$
Health Insurance		
Life Insurance		
*Other Compensation:		
Total Compensation		$

*Includes but is not limited to the following:

1. Supplies and services for personal use of the owner
2. Merchandise ordered from wholesalers for the owner's personal use.
3. Wages of a domestic or other employee who works in the home of the owner.
4. Personal use of a car, truck or other equipment owned by the facility.
5. Personal insurance premium paid for the owner.
6. Consultant fees.
7. Directors' fees.

If the facility is a corportation, was the entire compensation paid within the cost reporting period or within 75 days of the close of the cost report period?

YES [X] NO [ ]

II. Patient care function for which compensation is claimed: (Check One)

[X] Administrator
[ ] Assistant Administrator
[ ] Other (Identify and give a brief work description)

III. Specific Duties of Function checked above:

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FORM 15 - OWNERS, OFFICERS AND DIRECTORS COMPENSATION

Facility Name

D/B/A (If Applicable)

Provider Number Period: From To

Name of Owner, Officer or Director

IV. DIRECT RESPONSIBILITY OF OWNER, OFFICER OR DIRECTOR for other functions: (Check where applicable)

[ ] Accounting
[ ] Purchasing
[ ] Personnel
[ ] Public Relations
[ ] Other (Please identify)_____

V. Percentage of Ownership in this facility. _____

VI. Did you have any interest in any other facilities in Mississippi or other states during the cost report period?

YES__X__ NO__X__

If yes, please complete the following:

Name of Facility	Address	Percentage of Ownership

Do you have any interest in any business providing goods or services to this facility or any other facility listed above?

YES __X__ NO __X__

If yes, complete the related organizations section on Form 8.

VII. Analysis of Compensation Paid to Relatives of Owners, Officers and Directors:

Persons Related to Owner, Officer or Director - Compensation paid to an employee who is an immediate relative of an owner of the facility is also reviewable under the test of reasonableness. For this purpose, the following persons are considered immediate relatives: (1) husband and wife; (2) natural parent, child and sibling; (3) adopted child and adoptive parent; (4) stepparent, stepchild, stepbrother and stepsister; (5) father-in-law, son-in-law, daughter-in-law, brother-in-law and sister-in-law; (6) grandparent and grandchild.

Name	Relationship	Position	Line Number Form 6	Amount Paid	Average Hours Worked Per Week

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FORM 15 - OWNERS, OFFICERS AND DIRECTORS COMPENSATION

Facility Name			
D/B/A (If Applicable)			
Provider Number		Period: From	To
Name of Owner, Officer or Director			
VIII.	**A.**	**Indicate the estimated AVERAGE number of hours worked by the owner, officer or director, for whom this form is completed, each week in patient care activities for this facility. This should include time in the facility and time away from the facility that is related to management of the facility.**	
	B.	**Estimated average hours spent each week in nonfacility activity including non-certified portion of the facility:**	
		Occupation:	
		Occupation:	
		Occupation:	
	C.	**Estimated average hours spent each week in activities for other facilities:**	
		Facility Name:	
		Facility Name:	
		Facility Name:	
		Facility Name:	
		Facility Name:	
		Facility Name:	
		Facility Name:	
	D.	**Total estimated AVERAGE number of hours worked each week (sum of A, B & C).**	

I HEREBY CERTIFY that I have examined the above and certify to the best of my knowledge and belief that the said contents of this Form 15 are true and correct statements.

_____

Signature of Owner, Officer or Director for Whom this Form is Completed

_____

Date

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Form 16 - Disclosure of Ownership

Facility Name

D/B/A (If Applicable)

Provider Number Period: From To

Name of Owner, Partners, Major Stockholders, and Officers	Title	Address	Percentage Owned	Amount of Compensation*
1. Sole Proprietor				
2. Partnership				
3. Corporation**				
Name of Corporat				
4. Governmental - Name of Government				

* Compensation includes salaries allocated from the home office/related management company.

** List all stockholders having a 5% or more ownership of outstanding capital stock, all corporate officers of the corporation and all members of the Board of Directors at each level of the corporate structure.

FORM 16

STATE OF MISSISSIPPI
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Form 17, Page 1 of 2 - Home Office or Related Mgmt Co Cost Report Expense Allocation Summary

Facility Name					Provider Number	
D/B/A (If Applicable)					Period: From	
Home Office					To	
Line No.	Account	Per General Ledger Column 1	Adjustemnts & All Directly Related Expenses Column 2	Expenses Directly Related to THIS Facility Column 3	Expenses to be Allocated Column 4	Allocated Expenses Column 5
1	**REVENUE**					
1-01	Management (Owned)					
1-02	Management (Non-Owned)					
1-03	Accounting					
1-04	Consulting					
1-05	Rental and Leasing					
1-06	Sale of Supplies					
1-07	Interest Oncome					
1-08	Other (Schedule 13)					
1-09	**TOTAL REVENUE**					
2	**EXPENDITURES**					
2-01	Salaries-Owners, Officers and Directors					
2-02	Salaries-Other					
2-03	FICA					
2-04	Group Insurance					
2-05	Pensions					
2-06	Unemployment Taxes					
2-07	Workmens' Comp					
2-08	Accounting					
2-09	Advertising					
2-10	Amortization					
2-11	Consultants (Schedule 14)					
2-12	Contracted Services					
2-13	Depreciation					
2-14	Director Fees					
2-15	Dues and Subscriptions					
2-16	Educational Seminars & Training					
2-17	Interest Expense					
2-18	Insurance					
2-19	Legal					
2-20	Rental & Leasing					
2-21	Repairs & Maintenance					
2-22	Supplies & Postage					
2-23	Taxes & Licenses (Schedule 15)					
2-24	Telephone					
2-25	Travel (Schedule 16)					
2-26	Utilities					
2-27	Other Expense (Schedule 17)					
2-28	Contributions					
2-29	Income Tax					
2-30	**Total Expenditures**					

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Form 17, Page 2 of 2 - Home Office or Related Mgmt Co Cost Report Expense Allocation Summary (Cont'd)

Facility Name		Provider Number	
D/B/A (If Applicable)		Period: From	
Home Office/Related Management Co.		To	
Line No.			Adjusted Expense
3	**CALCULATION OF ALLOWABLE EXPENDITURES**		
3-01	Expenditures Directly Related to this Facility (From Form 17 - Page 1 of 2, Line 2-30, Col		
3-02	Expenditures Allocated to this Facility (From Form 17, Page 1 of 2, Line 2-30, Column 5)		
3-03	**TOTAL ALLOWABLE EXPENDITURES (To Form 6, line 4-38, Column 5)**		$

4	PROVIDE A BRIEF DESCRIPTION OF THE METHODS USED TO ALLOCATE EXPENSES TO THIS FACILITY:

SHOW THE ALLOCATION CALCULATION:

Please reference the following page, "Home Office Allocation Calculation(s)", with allocation method(s) and calculation(s).

Home Office Allocation Calculations

Home Office/Related Management Co

Period From: To:

Facility Name: Provider Number:

D/B/A (If Applicable)

Total Allowable Costs: Type 1 Unit: Type 2 Unit:
(Type 1 Used for Allocations Made in Cost Report)

Vendor Number	Facility Name	# of Type 1 Units	% Type 1 Units Allocated	Type 1 Allocated Costs	# of Type 2 Units	% Type 2 Units Allocated	Type 2 Allocated Costs

Totals:

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Form 18 - Computation of Return on Net Working Capital for Home Office

Facility Name	Provider Number	
D/B/A (If Applicable)		
Facility Reporting Period: From	To	
Home Office Name		
Home Office Reporting Period: From	To	

Description	Beginning	Ending
Equity Capital	$	$
Additions:		
	$	$
Reductions:		
	$	$
Net Equity	$	$

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Schd 1 - Other Income (Form 5, Line 13)

Facility Name

D/B/A (If Applicable)

Provider Number Period: From To

DESCRIPTION	Column 1 PER GENERAL LEDGER	Column 2 Medicaid Certified Portion of Long Term Care Facility	Column 3 ADJUSTMENT TO FORM 6 COLUMN 4	Column 4 FORM 6 LINE # ADJUSTED
Total (Must agree with Form 5, Line 13)	$	$	$	

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Schd 2 - Direct Care Allocated Costs - Hospital Based and State Facilities (Form 6, Line 1-17)

Facility Name

D/B/A (If Applicable)

Provider Number Period: From To

HOSPITAL COST REPORT WORKSHEET B, PART 1 LINE NUMBER	HOSPITAL COST REPORT WORKSHEET B, PART 1 COLUMN NUMBER	FORM 6 EXPENSE PER BOOKS Column 1	FORM 6 RECLASSI-FICATIONS Column 2	FORM 6 TOTAL EXPENSE Column 3	FORM 6 ADJUSTMENTS Column 4	FORM 6 ALLOWABLE EXPENSE Column 5
Total (Must agree with Form 6, Line 1-17)		$	$	$	$	$

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Schd 3 - Therapy Allocated Costs - Hospital Based and State Facilities (Form 6, Line 2-16)

Facility Name

D/B/A (If Applicable)

Provider Number Period: From To

HOSPITAL COST REPORT WORKSHEET B, PART 1 LINE NUMBER	HOSPITAL COST REPORT WORKSHEET B, PART 1 COLUMN NUMBER	FORM 6 EXPENSE PER BOOKS Column 1	FORM 6 RECLASSI-FICATIONS Column 2	FORM 6 TOTAL EXPENSE Column 3	FORM 6 ADJUSTMENTS Column 4	FORM 6 ALLOWABLE EXPENSE Column 5
Total (Must agree with Form 6, Line 2-16)		$	$	$	$	$

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Schd 4 - Care Related Allocated Costs - Hospital Based and State Facilities (Form 6, Line 3-23)

Facility Name						
D/B/A (If Applicable)						
Provider Number			Period: From		To	
HOSPITAL COST REPORT WORKSHEET B, PART 1 LINE NUMBER	**HOSPITAL COST REPORT WORKSHEET B, PART 1 COLUMN NUMBER**	**FORM 6 EXPENSE PER BOOKS Column 1**	**FORM 6 RECLASSI-FICATIONS Column 2**	**FORM 6 TOTAL EXPENSE Column 3**	**FORM 6 ADJUSTMENTS Column 4**	**FORM 6 ALLOWABLE EXPENSE Column 5**
Total (Must agree with Form 6, Line 3-23)		$	$	$	$	$

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Schd 5 - Miscellaneous (Form 6, Line 4-37)

Facility Name

D/B/A (If Applicable)

Provider Number Period: From To

DESCRIPTION	EXPENSE PER BOOKS Column 1	RECLASSI-FICATIONS Column 2	TOTAL EXPENSE Column 3	ADJUSTMENTS Column 4	ALLOWABLE EXPENSE Column 5
Total (Must agree with Form 6, Line 4-37)	$	$	$	$	$

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Schd 6 - Taxes & Licenses (Form 6, Line 4-43)

Facility Name

D/B/A (If Applicable)

Provider Number Period: From To

DESCRIPTION	EXPENSE PER BOOKS Column 1	RECLASSI-FICATIONS Column 2	TOTAL EXPENSE Column 3	ADJUSTMENTS Column 4	ALLOWABLE EXPENSE Column 5
Total (Must agree with Form 6, Line 4-43)	$	$	$	$	$

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Schd 7 - Travel (Form 6, Line 4-45)

Facility Name

D/B/A (If Applicable)

Provider Number Period: From To

START DATE OF TRAVEL	END DATE OF TRAVEL	NAME OF PERSON TRAVELING	TITLE OF PERSON TRAVELING	PURPOSE OF THE TRIP	DESTINATION	EXPENSE DESCRIPTION	EXPENSE PER BOOKS Column 1	RECLASSIFI-CATION Column 2	TOTAL EXPENSE Column 3	ADJUSTMENTS Column 4	ALLOWABLE EXPENSE Column 5
Total (Must agree with Form 6, Line 4-45)							$	$	$	$	$

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Schd 8 - Administrative and Operating Allocated Costs - Hospital Based and State Facilities (Form 6, Line 4-47)

Facility Name

D/B/A (If Applicable)

Provider Number Period: From To

HOSPITAL COST REPORT WORKSHEET B, PART 1 LINE NUMBER	HOSPITAL COST REPORT WORKSHEET B, PART 1 COLUMN NUMBER	FORM 6 EXPENSE PER BOOKS Column 1	FORM 6 RECLASSI-FICATIONS Column 2	FORM 6 TOTAL EXPENSE Column 3	FORM 6 ADJUSTMENTS Column 4	FORM 6 ALLOWABLE EXPENSE Column 5
Total (Must agree with Form 6, Line 4-47)		$	$	$	$	$

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Schd 9 - Property and Equipment Allocated Costs - Hospital Based and State Facilities (Form 6, Line 5-08)

Facility Name

D/B/A (If Applicable)

Provider Number Period: From To

HOSPITAL COST REPORT WORKSHEET B, PART 1 LINE NUMBER	HOSPITAL COST REPORT WORKSHEET B, PART 1 COLUMN NUMBER	FORM 6 EXPENSE PER BOOKS Column 1	FORM 6 RECLASSI-FICATIONS Column 2	FORM 6 TOTAL EXPENSE Column 3	FORM 6 ADJUSTMENTS Column 4	FORM 6 ALLOWABLE EXPENSE Column 5
Total (Must agree with Form 6, Line 5-08)		$	$	$	$	$

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Schd 10 - Other Non-Allowable Costs (Form 6, Line 6-10)

Facility Name

D/B/A (If Applicable)

Provider Name Period: From To

DESCRIPTION	EXPENSE PER BOOKS Column 1	RECLASSI-FICATIONS Column 2	TOTAL EXPENSE Column 3	ADJUSTMENTS Column 4	ALLOWABLE EXPENSE Column 5
Total (Must agree with Form 6, Line 6-10)	$	$	$	$	$

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Schd 11 - Non-Allowable Allocated Costs - Hospital Based and State Facilities (Form 6, Line 6-15)

Facility Name

D/B/A (If Applicable)

Provider Number Period: From To

HOSPITAL COST REPORT WORKSHEET B, PART 1 LINE NUMBER	HOSPITAL COST REPORT WORKSHEET B, PART 1 COLUMN NUMBER	FORM 6 EXPENSE PER BOOKS Column 1	FORM 6 RECLASSI-FICATIONS Column 2	FORM 6 TOTAL EXPENSE Column 3	FORM 6 ADJUSTMENTS Column 4	FORM 6 ALLOWABLE EXPENSE Column 5
Total (Must agree with Form 6, Line 6-15)		$	$	$	$	$

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Schd 12 - Deposits (Form 11, Line 19)

Facility Name

D/B/A (If Applicable)

Provider Number Period: From To

DESCRIPTION	Column 1 Beginning of Reporting Period	Column 2 End of Reporting Period
Total (Must agree with Form 11, Line 19)	$	$

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Schd 13 - Home Office or Related Mgmt Co Other Income (Form 17, Line 1-08)

Facility Name		
D/B/A (If Applicable)		
Provider Number	Period: From	To
Home Office/Related Management Company		
DESCRIPTION	**PER GENERAL LEDGER Column 1**	**ADJUSTMENTS Column 2**
Total (Must agree with Form 17, Line 1-08	$	$

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Schd 14 - Home Office or Related Mgmt Co Consultants (Form 17, Line 2-11)

Facility Name

D/B/A (If Applicable)

Provider Number Period: From To

Home Office/Related Management Company

NAME OF CONSULTANT	TYPE OF CONSULTANT	PER GENERAL LEDGER Column 1	ADJUSTMENTS Column 2	DIRECTLY RELATED EXPENSES Column 3	EXPENSES TO BE ALLOCATED Column 4	ALLOCATED EXPENSES Column 5
Total (Must agree with Form 17, Line 2-11)		$	$	$	$	$

DOM 501-15
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STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID
LONG-TERM CARE PROVIDERS

Schd 15 - Home Office or Related Mgmt Co Taxes & Licenses (Form 17, Line 2-23)

Facility Name

D/B/A (If Applicable)

Provider Number Period: From To

Home Office/Related Management Company

DESCRIPTION	PER GENERAL LEDGER Column 1	ADJUSTMENTS Column 2	DIRECTLY RELATED EXPENSES Column 3	EXPENSES TO BE ALLOCATED Column 4	ALLOCATED EXPENSES Column 5
Total (Must agree with Form 17, Line 2-23)	$	$	$	$	$

STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID
LONG-TERM CARE PROVIDERS

Schd 16 - Home Office or Related Mgmt Co Travel (Form 17, Line 2-25)

Facility Name
D/B/A (If Applicable)
Provider Number Period: From To
Home Office/Related Management Company

START DATE OF TRAVEL	END DATE OF TRAVEL	NAME OF PERSON TRAVELING	TITLE OF PERSON TRAVELING	PURPOSE OF THE TRIP	DESTINATION	EXPENSE DESCRIPTION	PER GENERAL LEDGER Column 1	ADJUSTMENTS Column 2	DIRECTLY RELATED EXPENSE Column 3	EXPENSE TO BE ALLOCATED Column 4	ALLOWABLE EXPENSE Column 5
Total (Must agree with Form 17, Line 2-25)							$	$	$	$	$

STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID
LONG-TERM CARE PROVIDERS

Schd 17 - Home Office or Related Mgmt Co Other Expense (Form 17, Line 2-27)

Facility Name

D/B/A (If Applicable)

Provider Number Period: From To

Home Office/Related Management Company

DESCRIPTION	PER GENERAL LEDGER Column 1	ADJUSTMENTS Column 2	DIRECTLY RELATED EXPENSES Column 3	EXPENSES TO BE ALLOCATED Column 4	ALLOCATED EXPENSES Column 5
Total (Must agree with Form 17, Line 2-27)	$	$	$	$	$

EXPLANATIONS OF RECLASSIFICATIONS IN FORM 6

Facility Name:

Provider Number: Cost Report Period From Cost Report Period To

RJE	Item	Form	Line	Schedule	Amount	Explanation

EXPLANATIONS OF ADJUSTMENTS IN FORMS 6 & 17

Facility Name:
Provider Number: Cost Report Period From: Cost Report Period To:

Form	Line	Schedule	Amount	Explanation